



## ACC NEWS



### President's Page: Role of the Cardiologist in Peripheral Vascular Disease

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We are witnessing an increasing interest in peripheral vascular disease among cardiologists. A field that had previously been left to the surgeons and radiologists in many practice environments is now attracting participation by cardiologists. Anthony DeMaria, MD commented on this trend 3 years ago in a President's Page (1) and defined the response of the American College of Cardiology. In this President's Page, I will expand on his excellent summary of the issues involved and the continuing efforts of the ACC to provide leadership in this area.

Changing perspective on the vascular component of heart disease. Why is vascular disease now attracting so much attention? My colleague, Jack Spittell, MD, has identified the primary stimulus for this trend as the lure of performing angioplasty in the peripheral vascular system (2). No doubt this is a major stimulus. However, in my judgment, the change in the types of disease that dominate the practice of cardiologists also explains why peripheral vascular disease is now of more importance to cardiologists. In my earliest days of clinical cardiology practice, in the early 1960s, the patients were primarily those with congenital and valvular heart disease. There was little investigation in patients with coronary artery disease because therapy was limited at that time. Moreover, patients with acute myocardial infarction were treated in an extremely conservative manner and, by today's standards, incorrectly. Although there was a high prevalence of coronary heart disease, its vascular component was not emphasized in the work of most cardiologists. This was reflected in my own institution, the Mayo Clinic, where separate sections for cardiology and peripheral vascular disease had been established.

Today, however, with the advances in early detection and treatment of congenital heart disease, the near eradication of rheumatic valvular disease, the introduction of coronary

arteriography by Sones (3) and an aging population, the components of adult clinical cardiology practice have changed dramatically. Our most common clinical problems are now truly vascular in origin. Furthermore, we are keenly aware that the disease process is not confined to the heart but frequently results in complicated clinical problems related to diffuse atherosclerosis. Thus the neat anatomic boundaries of the heart (or proximal aorta) no longer provide a clear distinction between "cardiology" and "vascular medicine." Our clinical practice now demands a recognition of the true systemic nature of vascular disease as an important part of diagnostic and therapeutic strategies.

**Education in vascular disease.** Although as cardiologists we are keen to apply our technology to patients with peripheral vascular involvement, we have not demonstrated a similar enthusiasm for emphasizing the broad educational requirements in vascular disease in our training. As emphasized by Spittell (2), there are important medical aspects to all vascular disease including the more unusual clinical problems. I can attest to this having observed the superb vascular clinicians in my own institution.

In addition, there is a growing awareness of the concept of vascular biology in the broadest sense with integration of knowledge that relates not only to the cardiovascular system but also to pulmonary and blood-related processes. A recent National Institutes of Health workshop on vascular biology emphasized new horizons for research that hold great potential for providing new insights into the diseases we treat as clinicians. Particular emphasis is on the biology of the endothelium and the vascular wall. In addition, the NIH has recognized the importance of stimulating integration of education and research programs and a broadened definition of cardiovascular disease. Two new programs of the NIH will address these new realities. The first is the Academic Award in Systemic and Pulmonary Vascular Disease designed to advance clinical care, research and education in the broadest sense. The second is an announcement of competition for

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program project grants in Vascular Biology in Medicine. It is hoped that such programs will encourage proposals that will stimulate innovative and interdisciplinary approaches to the problems of vascular disease unrelated to arbitrary anatomic boundaries.

These trends in clinical practice, education and research should be sufficient to justify an awakening of interest in the cardiology community on the importance of vascular disease, even without the confrontation of turf issues that unfortunately seem unavoidable in the practice arena.

**Role of the ACC.** How should the American College of Cardiology respond? Under the leadership of then ACC President DeMaria, the Board of Trustees agreed with the Strategic Planning Committee that the College needed to respond to these trends. Thus, in 1988 a Peripheral Vascular Disease Committee was formed and Dr. Jack Spittell was asked to chair it. Just 3 years later, the Committee is active in providing information and proposals to the ACC leadership on practice and education issues. For instance, the opportunities for ACC fellowship of individuals having a primary interest in peripheral vascular disease have been recognized by the Credentials Committee on the basis of specific input by the Peripheral Vascular Disease Committee. In addition, the Committee is in the process of making recommendations on important issues of training in peripheral vascular disease. As we consider vascular disease in the broadest sense, the Strategic Planning Committee is also examining the need for a committee on hypertension.

I want to highlight the role of the ACC in providing leadership in achieving expanded training in vascular disease within cardiology training programs. Training in peripheral vascular disease should encompass bedside clinical examination and pathophysiology, not just imaging and interventional training. At the same time, we need to expand training

in hypertension and lipid disorders as well. For cardiologists who do wish to establish expertise in interventional and imaging procedures in the peripheral vascular system, the curriculum required to accomplish such credentials needs to be clearly defined, ideally in collaboration with vascular surgeons and radiologists. Although the subspecialty boards in cardiac disease in adults have always been labeled "cardiovascular," it is well recognized that the amount of formal training in peripheral vascular disease is minimal to nonexistent in most adult cardiology fellowships. This needs to be corrected. I personally believe it is essential for the American Board of Internal Medicine to be convinced of the need to expand the recognition of vascular disease in the process of board certification and to provide opportunities for demonstration of special qualifications in vascular medicine similar to those provided for physicians trained in electrophysiology.

I strongly support the efforts to date of the ACC and urge continued attention to this important issue of vascular medicine and its significance to cardiologists. We are off to a good start, but without further emphasis on improving education in vascular medicine in our cardiology programs, and insisting on recognition of such special knowledge, we will lose our influence on the practice, education and research issues that confront us in a large component of our practice.

## References

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